DUR Board Meeting Minutes Draft

Name of Meeting	Drug Utilization Review Board
Date of Meeting	Thursday, April 26, 2007
Length of Meeting	2:09 PM – 4:14 PM
Location of Meeting	DMAS Board Room 13th Floor

Members Present:
Geneva Briggs, PharmD
Bill Rock, PharmD
Jane Settle, NP
Jason Lyman, MD
Jonathan Evans, MD, MPH

Not Present:
Jennifer Edwards, PharmD
Randy Ferrance, MD
Renita Warren, PharmD
Avtar Dhillion, MD
Elaine Ferrary, MS

DMAS Attendees:
Bryan Tomlinson, Health Care Services Division Director
Katina Goodwyn, Contract Manager
Rachel Cain, PharmD
Keith Hayashi, R.Ph
Tyrone Wall, Compliance Specialist

Contractor:
Donna Johnson, R.Ph, First Health Services Corporation
Debbie Moody, R.Ph, First Health Services Corporation

Visitors:
Anne Leigh Kerr, Troutman Sanders/ PHARMA
Darren Ray, Amylin
Richard Grossman, Vectre
Brad Lanham, BMS
Frankie Rutledge, CNS

Call to Order and Introductions

Chair Geneva Briggs called the meeting to order.

Rachel Cain introduced Frankie Rutledge from Comprehensive NeuroScience.

The Board had to bypass approval of the minutes until the next DUR Board Meeting due to lack of a quorum

Dose Optimization and Maximum Quantity Limits Program Draft

The DMAS Pharmacy staff promoted a proposal for the implementation of an expanded dose optimization and maximum quantity limits programs. These are standard pharmacy cost management practices in the commercial sector and other state Medicaid programs. Currently, the DMAS drug utilization review program includes similar reviews of excessive quantities. No regulatory, systems changes or additional costs are required with the first phases of these initiatives.

Establishing maximum quantity limits consists of identifying high cost products where a 34-day supply is defined by a set number of tablets. This strategy establishes quantity limits based on common dosing practices. For example with Fosamax 35/70 mg tablets, the industry standard is four tablets in a 34-day supply. Some of the drug classes that would be most appropriate for maximum quantity limits include anti-emetics, anti-migraine agents, and narcotics.

Review by Drug Utilization Review (DUR) Board:

The proposed list of drugs for both initiatives was discussed by the DUR Board. The process for determining the proposed quantity limits and reference materials from the manufacturer and/or other drug reference resources for these drugs were also discussed. Based on the information presented and the DUR Board members' clinical experience, they will either approve the proposed criteria or revise them. There was consensus on the value and proposed procedures for implementing this new pharmacy management initiative.

Summary of Behavioral Pharmacy Management System Enhancements 2007

DMAS staff announced the proposed transition of the CNS behavioral pharmacy program to the DUR Board. The program was well received by the Board.

Comprehensive NeuroScience announced the release of an upgraded version of the Behavioral Pharmacy Management (BPM) system for 2007. Many of the system enhancements are aimed at reducing or eliminating false positives and will result in more clinically relevant intervention. Some important changes include:

Age Calculation: the new system will calculate the patient's age at the end of the 90-day reporting period rather than at the beginning of the reporting period. This enhancement eliminates the inclusion of an individual who may have "aged out" of a product. For example an adolescent who turns 18 during the first month of the 3-month analysis period will be evaluated as an Adult, not a 17 year-old. This is especially important in high dose indicators where different dosing limits exist for ages 13 through 17 versus 18 and over.

Application of Medication Possession Ratio (MPR): in all previous CNS BPM releases, the system evaluated "consecutive days" to determine whether or not a patient

was using a medication continuously. Allowances were made by the system for early and late refills, which were somewhat restrictive and arbitrary. By implementing an approach of calculating the percentage of time a patient had possession of a medication during the reporting period, early and late refills are evaluated more accurately. BPM 2007 uses a threshold of an 80% MPR for a patient to be considered as using a medication consistently throughout the analysis period.

Criteria for Indicators must exist in the last 30 days of the reporting period: in BPM 2007 a patient will be flagged by an indicator if, and only if, the associated medication was available to the patient within the last 30 days of the reporting period. This data validation eliminates flagging prescribing practices that occurred in the only the first or second month of the reporting period.

PRN Use: the new system no longer evaluates any prescriptions for medications whose calculated daily dose (quantity/days supplied) is less than a half tablet per day, which likely reflects PRN usage--not pill splitting.

Empty Values: all claims received from the client without a prescribing physician ID will be rejected by the system during the data load process. Clients will receive a report showing the claims not processed for this reason. This may result in patients not being flagged by an indicator when they should have been due to pharmacy errors.

Calculating High Dosing: previous BPM versions used the mean dose for a 90-day period to identify patients receiving medications at a higher-than-recommended dose, which may have resulted in false positives. BPM 2007 uses a much more sophisticated algorithm and eliminates high dose values due to early refills alone.

Specialty Drug Program

Bryan Tomlinson explained the Specialty Drug Program to the DUR Board members and their potential role in the management of this program. A therapeutic class review was done for Antiretroviral agents.

Ad hoc Reports

The DUR Board member reviewed Fentora®, Narcotics, Zelnorm® Smoking Cessation and Quetiapine utilization for service period 11/1/2006 to 1/31/2007.

RetroDUR Review Reports October, November and December 2006

October 2006 Drug Review

The Retrospective Drug Utilization Review process for October 2006 reviewed drug claims for September 2006. This month's review involved two topics – a review of criteria exceptions for the new drugs approved by the DUR Board at the August 2006 meeting and a review of non-compliance with ACE inhibitor therapy.

Profiles for patients meeting criteria on *Amitiza* (lubiprostone), *Emsam* (transdermal selegiline), *Azilect* (rasagiline), *Chantix* (varenicline) and *Exubera* (inhaled insulin) were reviewed for drug interactions, therapeutic duplication, high dose and drug to disease interactions. A total of 4 letters were sent to prescribers informing them of the potential risk to their patients. The issues addressed by the letters consisted of one high dose of lubiprostone, one drug-disease interaction for lubiprostone, one therapeutic duplication of lubiprostone with tegaserod and one therapeutic duplication of rapid insulins.

Medication non-compliance is prevalent among patients with conditions such as hypertension and diabetes mellitus and is often associated with adverse outcomes. Interventions are needed to increase medication adherence so that patients can realize the full benefit of prescribed therapies. Profiles for patients who are 10 or more days late in refilling ACE Inhibitor prescriptions were reviewed. Staff reviewed patients who were habitually late in filling these medications. A total of 158 letters were sent to prescribers to alert them to the potential compliance problem with their patients' therapy.

There were also re-reviews in October for the January 2006 review of new drug criteria approved by the DUR Board at the November 2005 meeting for entecavir, exenatide, ibandronate, pramlintide, pregabalin, ramelteon and tipranavir. For the original review, 49 letters were sent to prescribers informing them of the potential risk to their patients. Of the patients involved in the original letters, 40 discontinued the medication, 1 decreased the dose and 8 showed no change to the original high dosage. No additional letters were sent to prescribers related to this issue.

November 2006 Drug Review

The Retrospective Drug Utilization Review process for November 2006 reviewed drug claims for October 2006.

The 2003 session of the Virginia General Assembly passed legislation requiring the Department of Medical Assistance Services to review its elderly long-term care enrollees for any inappropriate use of medications as defined by Dr. Mark Beers. [1] Dr. Beers published several articles describing the inappropriate use of various medications in older adults. The Beers criteria were presented to the VA Medicaid DUR Board for review and approval. The Board approved the criteria and agreed that this review would be performed every 6 months as a retrospective review of 1000 enrollee medication profiles. Additionally, the Board recommended that the review should include all VA Medicaid enrollees 65 years and older, not just those in long-term care facilities.

With the implementation of the Medicare part D pharmacy drug plan, Medicaid no longer covers the majority of the medications on the Beers List. However, two major classes of drug are excluded by Medicare and are covered by Medicaid. These are the benzodiazepines and barbiturates. Additionally, Medicare Part D does not cover over-the-counter (OTC) medications. OTC medications such as antihistamines and decongestants are included in the Beers criteria. Therefore, the focus of this review is on the Beers criteria for these types of medications. One thousand medication profiles were generated for all enrollees 65 years and older who met any of the Beers criteria for benzodiazepines, barbiturates or OTCs. There were a total of 206 letters sent to prescribers whose patients are receiving medications or dosages that are potentially inappropriate for them. If a prescriber responded to a previous letter that the treatment was clinically appropriate, no letter was sent for this review. It is assumed that the prescriber has evaluated the risks versus the benefits of using one of these medications in their older patient.

Of particular interest in this review was that 44.4% of the criteria interventions involved the use of benzodiazepines in doses that exceed the recommended maximum dose in older adults; 34.3% involved the use of benzodiazepines or barbiturates that are inappropriate to use in older adults at any dosage; and 21.3% of the interventions involved the use of benzodiazepines that are not recommended in patients with certain medical conditions. Overall, the inappropriate use of these medications can lead to prolonged sedation and an increased incidence of falls and fractures in the older adult patient.

There were also re-reviews in November for the February 2006 Polypharmacy intervention. For the original review, letters were sent to prescribers concerning 64 patients with polypharmacy. Of these original 41 patients, only 3 continue to show polypharmacy. The majority of the letters were sent regarding patients who are now enrolled in Medicare Part D. Since most of their medications are covered by Medicare Part D, it is not possible to evaluate the utilization for the majority of these medications as no claims history is available.

[1] **Fick DM, Cooper JW, et al. Updating the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults.** ***Arch Intern Med.*** **2003;163:2716-2724.**

December 2006 Drug Review

The Retrospective Drug Utilization Review process for December 2006 reviewed drug claims for November 2006. This month's review focused on non-compliance with beta-blocker therapy.

Medication non-compliance is prevalent among patients with conditions such as hypertension, diabetes mellitus and heart disease and is often associated with adverse outcomes. Interventions are needed to increase medication adherence so that patients can realize the full benefit of prescribed therapies. Profiles for patients who are 10 or more days late in refilling beta blocker prescriptions were reviewed. Staff looked for patients who were habitually late in filling these medications. A total of 193 letters were sent to prescribers to alert them to the potential compliance problem with their patients' therapy.

There were also re-reviews in December for the March 2006 review of long-acting beta agonist (LABA) utilization. In November 2005, the FDA requested manufacturers of LABAs to update their existing product labels with new warnings. The information in the FDA's proposed changes to the product labels explains that, even though LABAs decrease the number of asthma episodes, these medicines may increase the chances of a severe asthma episode when they do occur. For the original review, 225 letters were sent to prescribers informing them of the potential risk to their patients. Of the patients involved in the original letters, 129 discontinued the medication and 96 remain on the LABA. No additional letters were sent to prescribers related to this issue.

RetroDUR Review Report January 2007

The Retrospective Drug Utilization Review process for January 2007 reviewed drug claims for December 2006. The topic of review was **polypharmacy**.

Patients who are seen by multiple prescribers and have their prescriptions filled at multiple pharmacies are at increased risk of medication related adverse events. These patients may lack a primary care physician and a single pharmacy to coordinate and optimize their medication regimen. The focus of this review was to evaluate patients who received greater than nine unique prescriptions in a 34-day period and these prescriptions were written by 3 or more different prescribers and filled at 3 or more different pharmacies. The profiles of **785** patients meeting these criteria were reviewed. Care was taken not to letter when the patients had obvious diseases or combination of diseases that could easily require more than nine prescriptions each month and possibly several doctors. Staff looked for patients who are chronically at risk for drug interactions, therapeutic duplication, or those who may be doctor or pharmacy shopping. A total of **111** letters (**14**%) were sent to prescribers informing them of their patients' polypharmacy and the potential risks.

Since the polypharmacy review was incorporated into the existing RetroDUR program in August 2005, approximately 5000 patient medication profiles have been reviewed and a total of **714** intervention letters have been sent to prescribers. A decline in the number polypharmacy criteria violations is now being observed. There were only 785 patient profiles generated in January for polypharmacy. This is in large part due to the establishment of Medicare Part D. Polypharmacy is seen predominately in the older adult population. These are the patients with the greatest number of comorbid diseases that require multiple prescribers and medications. However, the issue of polypharmacy still exists in the remaining population and the prescribers are receptive to the information that is provided. The overall prescriber response rate is **22%** with **62%** of these prescribers responding that they find the information useful and plan to monitor, alter or discontinue the treatment regimen.

There were also **72** re-review profiles for the May 2006 review of antibiotics used to empirically treat upper respiratory infections. Of the profiles reviewed, **48** showed the discontinuation of antibiotic drug therapy while **18** profiles showed the continued use of antibiotics in these patients. This review was purely to inform the prescribers of the CDC's National Campaign to reduce the rate of antibiotic resistance. The patients who continued to receive antibiotic therapy may have identified bacterial infections that require antibiotic therapy. No additional letters were sent to prescribers notifying them of the continued existence of the original issue.

Annual CMS and General Assembly Reports on Drug Utilization Reviews

The Board was given a copy of the Annual CMS and General Assembly Reports for review.

Next Meetings: August 2, 2007 and November 8, 2007
Adjournment: 4:14 P.M.